HOME Choice Consumer Advisory Council
Membership Interest Form

Directions: Please complete the below form if you would like to refer a person to serve on the HOME Choice Consumer Advisory Council or you are the person who would like to serve on the HOME Choice Consumer Advisory Council. The Council will not accept members who are advocates/providers of persons who are elderly and/or have disabilities. Only persons who are elderly and/or have disabilities receiving services and supports regardless of payer source for such services may apply. You do not have to be a participant of the HOME Choice Transition program to apply.

APPLICANT INFORMATION	
Name of Applicant:	
Address of Applicant:	
Daytime Phone Number of the Applicant:	
Evening Phone Number of the Applicant:	
E-Mail Address of the Applicant:	
Age of Applicant:	
Are you a member of:	☐ Ohio Developmental Disabilities Council ☐ Ohio Olmstead Task Force ☐ People First ☐ Local Self-Advocacy ☐ Other:_____ ☐ None
Do you belong to any boards, committees and/or organizations? If so, specify.	
What Health and Supportive Services Coverage do you have?	☐ Employer Coverage ☐ Medicaid ☐ Medicare ☐ Individual ☐ Uninsured

Ohio Developmental Disabilities Council

Specify the types of health and/or supportive services you receive currently.	
Specify the category you expect to represent.	☐ person with DD ☐ person who are elderly ☐ person with physical disabilities ☐ family and/or legal representative of a child with a disability ☐ person with mental illness ☐ person with traumatic brain injury ☐ person in active recovery from alcohol and/or other drug addiction/abuse
Given that your role on the council will involve issues of long term services and supports system reform, what are your interests?	☐ Housing ☐ Health and Social Support Workforce ☐ Persons with disabilities in the workforce ☐ Services ☐ Supports ☐ Self-Direction ☐ Unified Budgeting ☐ Care Management ☐ Other_____
Do you need any accommodations to participate on the council?	☐ Yes ☐ No
If yes, please specify.	
Why do you want to be considered for membership?	

REFERRAL INFORMATION (IF APPLICABLE)	
Name:	
Relationship to Applicant:	
Daytime Phone Number:	
Evening Phone Number:	
E-Mail Address:	

Submit the interest form electronically or by mail by **June 1, 2010** to:

Shelley Papenfuse
Ohio Olmstead Taskforce/Chair
The Ability Center of Greater Toledo
5605 Monroe St.
Sylvania, OH 43560
shelley@abilitycenter.org